Instructions - Open Enrollment Change Request Form for Retirees

The Open Enrollment Period allows you the opportunity to change your health plan, add eligible dependents, or enroll in a health plan. To make an Open Enrollment change, simply complete the request form (HBD-30) and mail to or call CalPERS. All changes are subject to verification of eligibility. Consult the ***CalPERS Health Program Handbook*** or call CalPERS for eligibility information.

Mail the HBD-30 and all other requests to:	**For further information, please call:**
CalPERS Health Benefit Services Division P.O. Box 942714 Sacramento, CA 94229-2714	Toll Free: (800) 237-3345 TDD: (916) 326-3240

INSTRUCTIONS FOR COMPLETING HBD-30	
PART A: Type of Change	Check the type of change(s) you are making.
PART B: Retiree Information	Complete all retiree information. Be sure to include the name of the agency from which you retired.
PART C: Health Plan	Before requesting to change plans, verify the doctor you want is accepting new patients. If not, you will need to find another doctor who contracts with the new plan.
PART D: Dependent Information	List only the dependents you are adding. All dependents currently enrolled on your health plan will remain on your plan. Dependents eligible to enroll are listed in the ***CalPERS Health Program Handbook***. Adding a spouse, domestic partner, or another person's child requires supporting documentation (see the ***Health Program Handbook)***. **Important:** If the dependent(s) you are adding are eligible for Part A and Part B of Medicare, a **copy** of their Medicare card or Notice of Entitlement letter must be returned with this form.
PART E: Signature	The signature of the retired member is required.

NOTE

- After changing your health plan, be sure to check your retirement check to verify that the proper deduction is made. If the deduction is incorrect, call CalPERS to report the discrepancy.
- If you are enrolled in a Managed Medicare plan (Medicare + Choice) and are switching to a Supplement to Original Medicare plan, you must contact your current health plan or the nearest Social Security Office to disenroll your Medicare benefits from your current Managed Medicare plan (Medicare + Choice). If you do not disenroll, Medicare will not pay your new health plan for services. For more information, refer to the ***Understanding Medicare & Your CalPERS Health Benefits*** booklet.

Do not use this form to cancel your health coverage or delete a dependent. Instead, make your request by calling or writing CalPERS. Include your Social Security number, daytime phone number, mailing address, the type of change, and the reason for change. The effective date for changes, other than Open Enrollment changes, is the first of the month following receipt of your request.

CalPERS

CalPERS Health Benefit Services Division
P.O. Box 942714
Sacramento, CA 94229-2714
(800) 237-3345/TDD (916) 326-3240

Changing Plans?
Open Enrollment plan changes can be done over the phone by calling (800) 237-3345.

Date Called:_____

Name of Representative:_____

To save time, complete this form before you call to request changes over the phone.

Open Enrollment Change Request Form For Retirees

(For Retirees Only. Active employees - contact your Personnel Office.)

Changes Effective January 1, 2001

PART A • TYPE OF CHANGE •

❒ **Change My Health Plan.** (complete Parts B, C, and E)
❒ **Add Eligible Dependents Onto My Health Plan.**** (complete Parts B, D, and E)
❒ **Enroll In A Health Plan.*** (complete Parts B, C, D, and E)

PART B • RETIREE INFORMATION •

Social Security Number	Last Name First Name MI	Retirement Date (MO/YR)

Date of Birth (MO/DAY/YR)	Home Address Mailing Address (if different)	Apt/Unit #

Daytime Phone Number	City State ZIP	County (residence)
( ) -		

Male ❒ Female ❒

Name of agency or school district retired from:

Are you or any of your dependents on Medicare disability?
Member ❒ Yes ❒ No
Dependent ❒ Yes ❒ No
If yes, send a copy of Medicare cards.

Are you or any of your dependents enrolled in both Parts A & B of Medicare?*
Member ❒ Yes ❒ No
Dependent ❒ Yes ❒ No
If yes, send a copy of Medicare cards.

PART C • HEALTH PLAN •

Name Of New Health Plan	Name Of Doctor/Medical Group

PART D • DEPENDENT INFORMATION •

Dependents To Be Added	Social Security Number	Date Of Birth	Relationship	Doctor or Medical Group

PART E • RETIREE'S SIGNATURE •

By signing this form, I elect to change to the plan indicated above and/or add eligible family members. I also authorize deductions, if applicable, to be made from my retirement allowance to cover my share of the cost of enrollment.

Signature Of Retiree	Date Form Signed

* You can enroll in the CalPERS Health Program if you:
- retired from the State of California, a school district, or public agency that contracts with CalPERS to provide health benefits for its retirees,
- are receiving a retirement check,
- were enrolled in the CalPERS Health Program at the time you retired, and
- retired within 120 days from the day you separated from your job.

** Adding a spouse requires a copy of your marriage license. Adding a domestic partner requires a Declaration of Domestic Partnership and a Statement of Financial Liability. Adding an economically-dependent child or a domestic partner's child requires an "Affidavit of Eligibility." Contact your former employer or CalPERS for more information concerning eligibility requirements.